

Dix-Eureka Medical Center
HIPAA PATIENT PERMISSIONS

Patient Name: _____ Date: _____

Patient Birth Date: _____

We take our HIPAA privacy obligations seriously. Traverse Health Clinic will use and disclose your health information consistent with what is explained our NOTICE OF PRIVACY PRACTICES (NOPP). The most common reasons why we use or disclose your health information is for treatment, payment or healthcare operations. If you wish to discuss how we use your health information as described in our NOPP, please ask to speak with the Privacy Officer or staff person. To better protect the privacy of your health information, please provide the following information:

1. May we discuss your health information with family or friend(s)?

Yes No If yes, identify up to 2 people below:

A. Name: _____

May this person pick up medications and paperwork on your behalf? Yes No

Relationship: _____

Home Phone: _____ Cell: _____

B. Name: _____

May this person pick up medications and paperwork on your behalf? Yes No

Relationship: _____

Home Phone: _____ Cell: _____

2. Whom should we call if you have an emergency? (List 2 people)

A. Name: _____

May we tell this person detailed health information about the emergency?

Yes No

Person's Home Phone: _____ Cell: _____

B. Name: _____

May we tell this person detailed health information about the emergency?

Yes No

Person's Home Phone: _____ Cell: _____

3. How would you like us to contact you? (select all that apply)

Home Phone OK to leave a detailed voice message? Yes No

Cell Phone OK to leave a detailed voice message? Yes No

Other Phone OK to leave a detailed voice message? Yes No

Mail Yes No

Address: _____

4. FOR AUTOMATED (ROBO CALL) MESSAGES:

I agree to use the following electronic services for automated messages.

(Please check each service that you agree to use)

_____ Automated phone message (Cell phone or land line)

_____ Text messages (Cell phone only)

Preferred phone number for all electronic messaging services _____

_____ I do not want to use any of these services

Preferred Language (circle ONLY one) English Spanish

Preferred Time to Call (circle ONLY one) Morning Afternoon Evening

Patient Signature: _____ Date: _____

If you are signing as a parent or a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Your Name: _____

Relationship to Patient: _____

Signature: _____

Source of Authority: _____

Attach relevant documents, if applicable, such as guardianship papers, power of attorney, etc.